Important!

Workers' Compensation Claims Information

EMPLOYEE:

- ☐ Immediately notify the supervisor that a work related injury or illness has occurred.
- ☐ Complete the "Injured Employee" Accident Report and give to supervisor.

SUPERVISOR:

- ☐ Assess the incident and assist the employee in seeking appropriate medical care or necessary treatment.
- ☐ Request a post-accident drug screening from the medical provider.
- ☐ Report the work-related injury, accident or illness within 24 hours to Propel HR by completing the "Supervisor's Incident Report."

REPORT ALL CLAIMS TO:

Susan Kain
Workers' Compensation
Manager skain@propelhr.com
Direct Line: (864) 679-6067
Direct Fax: (864) 335-4769

IMPORTANT! If an employee seeks medical treatment prior to reporting a work related injury or illness to employer, medical expense reimbursement may be denied.

Supervisor's Incident Investigation Report

Employer Data

Company Name: ______________________________

Company Address: ______________________________

Phone: ____________________ FEIN #: ____________________

Employee Data

Employee Name: ______________________________
Last *First* *M.I.*

Home Address: ____________________ Phone Number: ____________________

Job Title: ____________________ Social Security #: ____________________

☐ Part Time ☐ Exempt Rate of Pay: ____________________

☐ Full Time ☐ Hourly Pay Frequency: ____________________

Date of Hire *(xx/xx/xxxx)*: ____________________ Date of Birth *(xx/xx/xxxx)*: ____________________

Department: ____________________ Shift Hours: ____________________

What days does employee work? ____________________

Was employee paid in full for the date of injury? ____________________

Incident Data

Incident Date: __________________________Time of incident: ____

Exact location of incident (including address): ____

Date reported to Company: ______________ Reported to whom (name, title, phone):____

Did employee return to work? ______________ Return date:____

Brief description of injury/illness (burn, fracture, strain, cut etc.:____

____

Body part affected: ____

Did employee visit the doctor? _____________________________________ Date of doctor visit _________________________

Doctor's Name and/or Facility: ____

List any witnesses: ____

Incident Details

Job or activity at time of incident ____

Describe clearly what occurred (How, when, where). Include diagram and pictures if needed.

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Supervisor Information

Report Completed By: ____

Job Title: ______________________ Signature: ______________________________

INJURED EMPLOYEE - ACCIDENT INVESTIGATION REPORT

This form is for reporting to management and may be submitted to the Insurance Company if petitioned to do so.

WHO WAS INJURED?	NAME_______________ OCCUPATION_______________ DEPARTMENT_______________
TIME AND PLACE	DATE_______________ TIME_______________ EXACT LOCATION_______________
DESCRIBE INJURY	_______________
A DETAIL ACTIONS PRIOR AND UP TO INJURY. WHAT HAPPENED? USE REVERSE SIDE TO EXTEND COMMENTS	
B WHAT UNSAFE CONDITION (S) OR ACT (S) CAUSED THIS ACCIDENT?	
HOW CAN SIMILAR ACCIDENTS BE AVOIDED?	
WHAT ACTION HAVE YOU TAKEN TO PREVENT SIMILAR ACCIDENTS?	

_______________ EMPLOYEE NAME-POSITION _______________ DATE

_______________ EMPLOYER NAME-POSITION _______________ DATE

EMPLOYER'S FIRST REPORT OF INJURY SUBMITTED _______________ DATE